59th Medical Wing

U.S. AIR FORCE

59 MDW Radiology Product Line Analysis Clinic Response

Information Brief
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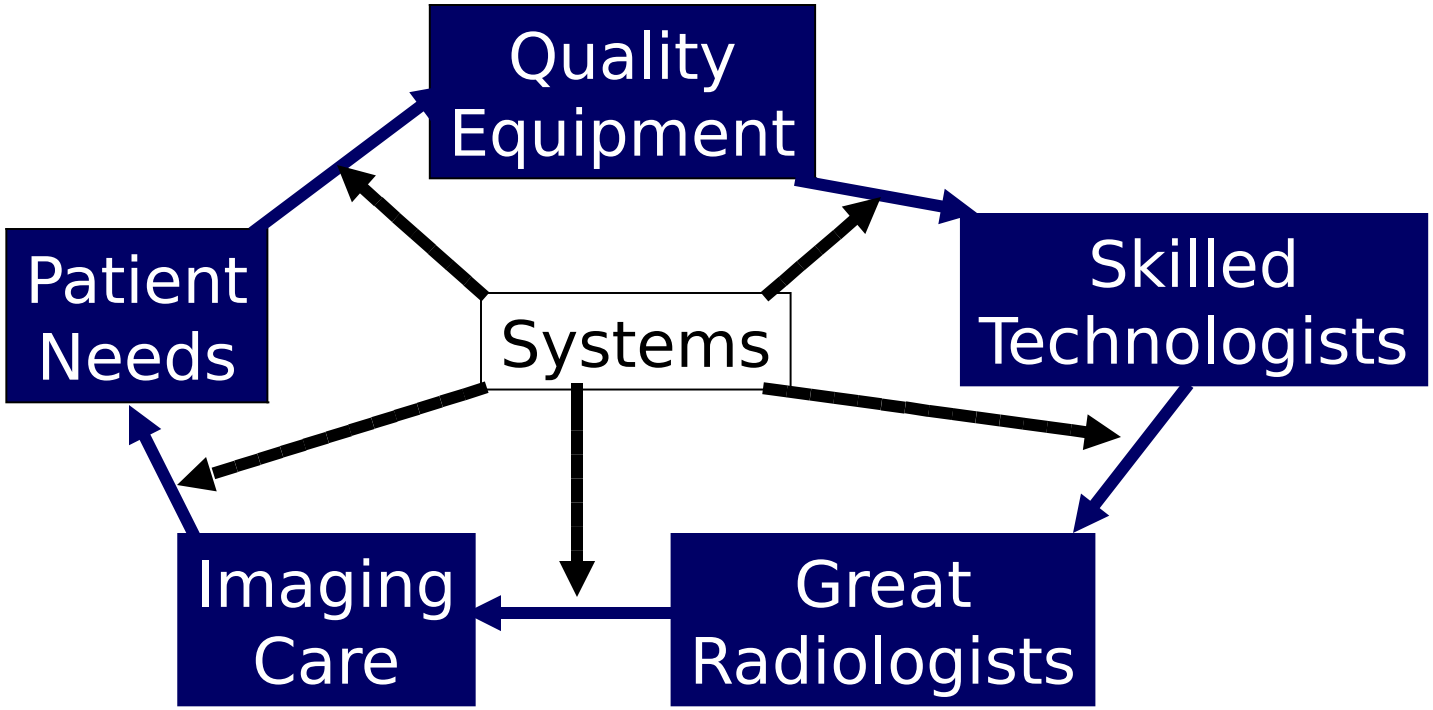
Date: 25 Mar 05

Overview

- Interventional Radiology Clinic
- Billing Limitations
- Systems
- Department Overview
  - MR
  - Nuclear Medicine
  - CT

"Challenges and Opportunities"

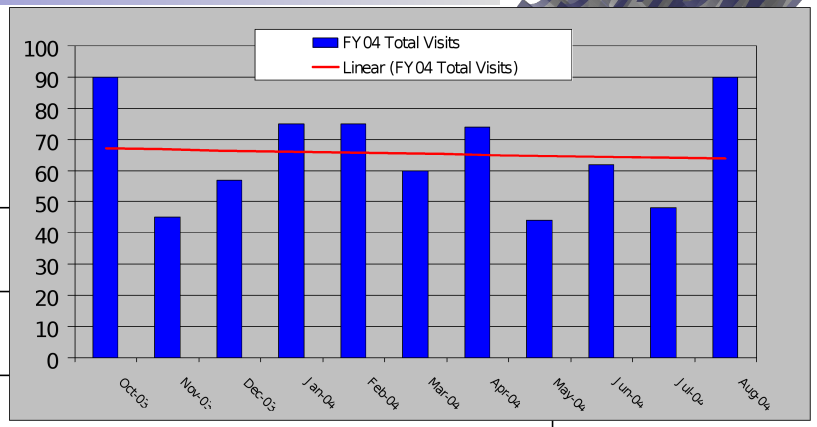
Formula for World Class Radiology Services

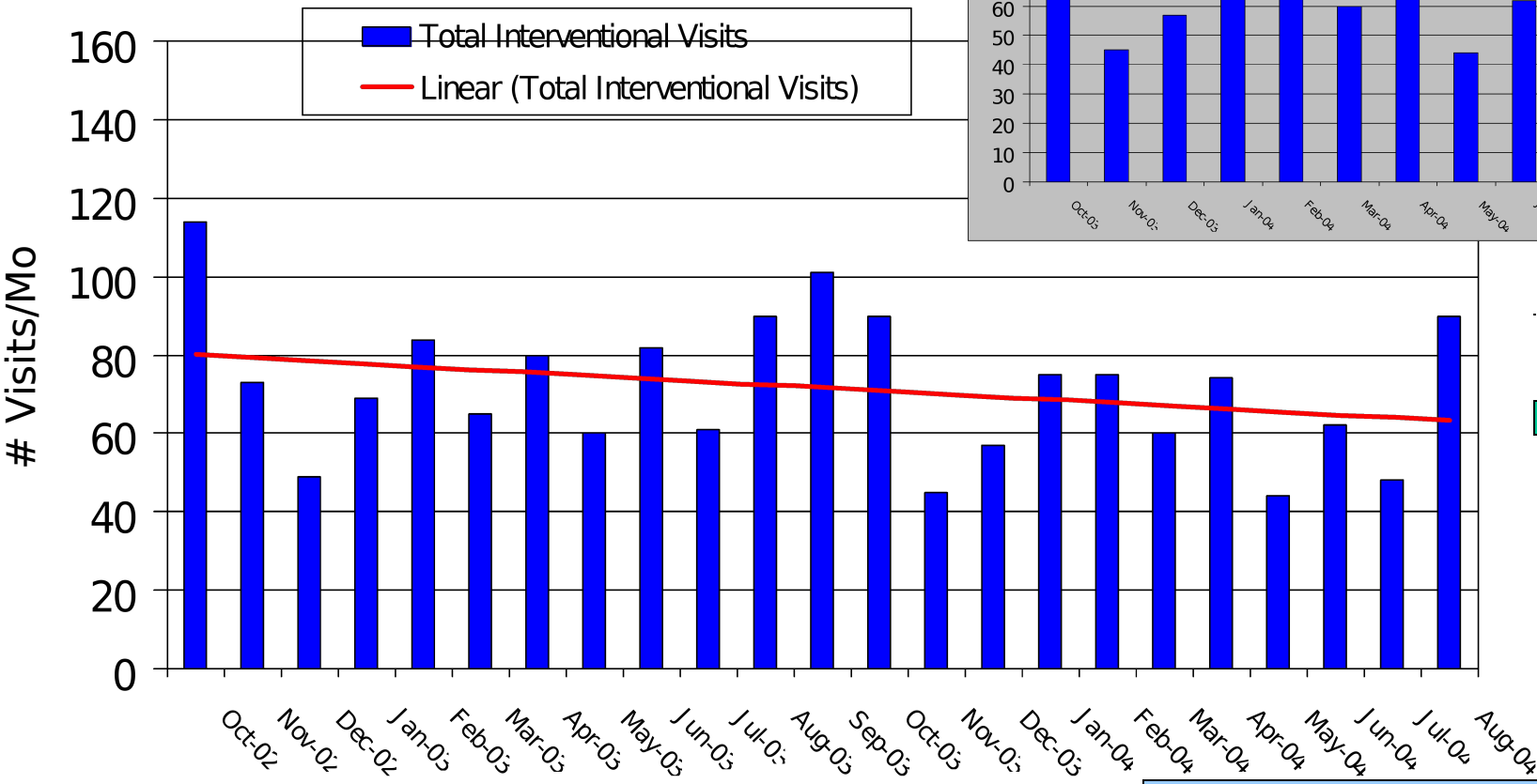


Interventional Radiology Clinic

- 35% decrease pt visits FY03 vs. 04
  - Decreased staff IR docs from 4 to 2
  - Vascular surgery referral patterns excluded IR
  - >65 yo most eligible for IR not being referred

Interventional Radiology
Total OP Visits FY03-04



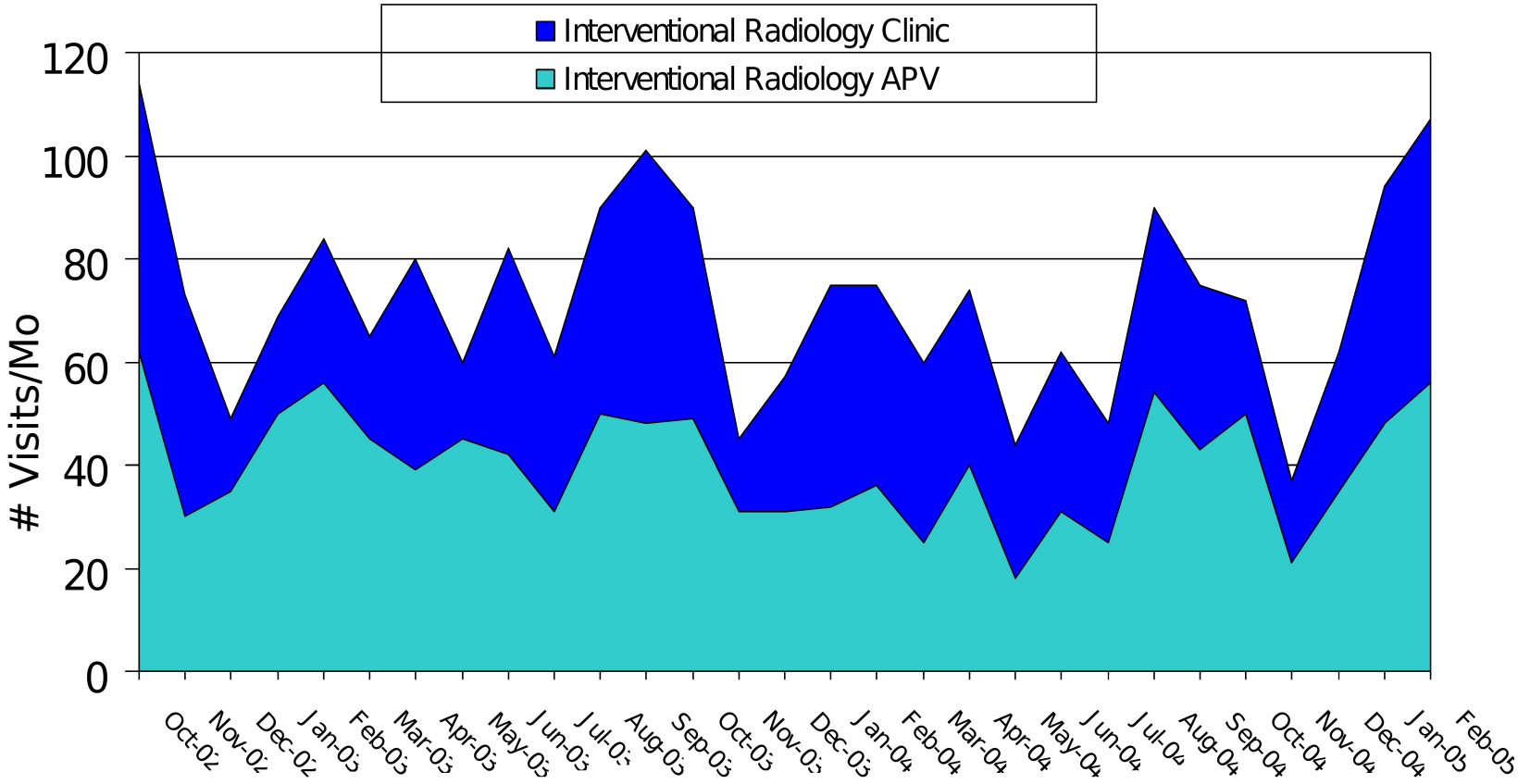


FY04 only

- Overall: -35% FY03 vs. FY04
- Slight Downward Trend in FY04 Only (*see inset*)

Source: Worldwide Workload
WHMC Intranet/E.I.C.

Interventional Radiology
Total OP Visits by Type FY03-04



- FY03 Avg:44 APVs /mo.; 33 Visits /mo.
- FY04 Avg: 35 APVs /mo.; 32 Visits /mo.
- Change: -20% APVs /mo.; -33% visits /mo.

Source: Worldwide Workload
WHMC Intranet/E.I.C.

Interventional Radiology Clinic

- "Walk-in" procedures
  - Interventional radiology (IR) does this as they are an outpatient clinic
- 52% of IR not coded
  - Follow-ups were "walked-in" but coders needed additional paperwork--corrected
- Step up production in Angio when new room opens (mid-Apr 05)
  - More 604 funds are needed— $300K

Interventional Radiology

Solution #1: recapture over 65 year old beneficiaries

Solution #2: recapture of TRICARE prime patients for neurointerventional and other limited high dollar interventional procedures from local and regional markets

Solution #3: actively working with vascular surgery for increased share of workload

Necessary condition: Estimated $300K in 604 $

Billing Limitations

- Lack of staff M.D. name on request
- CHCS files and tables
- No mechanism for billing professional portion of diagnostic imaging exams
- Local interface with dedicated coder

Billing Limitations - Outpatient

- Lack of staff M.D. name on request
  - CHCS: No current mechanism to designate resident M.D. with privileges that require radiology study counter-signature—CHCS II may have provision
    - Solution #1: have non-M.D.’s put in request. Working in ED with admin support, but question scalability to other outpatient clinics.
    - Solution #2: SAIC/CHCS currently will not change the privileges. Request was denied.

Billing Issues Addressed

- CHCS files and tables
  - CPT code for exams embedded in CHCS
    - Automatic CPT code updates periodically
  - Streamline orders to facilitate referring providers ordering correct exam
  - Ultrasound, CT and Mammo updated with BAMC
  - IR, MR, Nucs and plain films scheduled

Billing Limitations

- No mechanism for billing professional portion of diagnostic imaging exams
  - Cannot Walk-In
  - Diagnostic radiology allocates to inpatient and outpatient MEPRS codes
  - MEPRS B vs. MEPRS D
    - Business rules for “B” require “face to face” by provider
  - DOD TMA UBU working group addressing
- Super bill option
  - Not needed due to CPT code in CHCS

Challenges and Opportunities

Dept Overview

- Increasing utilization of Radiology services
  - Workload increases while MAPPG06 decreases 10 techs (10% of total)
    - Reclama for tech cuts disapproved at wing level
  - Continued deployment picture compounds
    - Technologists: 3 in 2003, 7 in 2004, 12 in 2005
  - Teleradiology empire
    - 1.5 FTE transcriptionists, 1.0 FTE techs--uncompensated
  - GME and Phase II negatively affected
    - 38 residents annually; 37 Phase II technicians
  - Quality of care may become tenuous

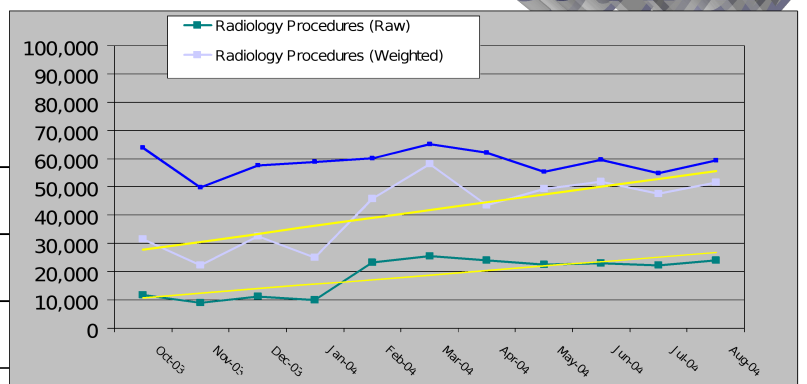
Challenges and Opportunities

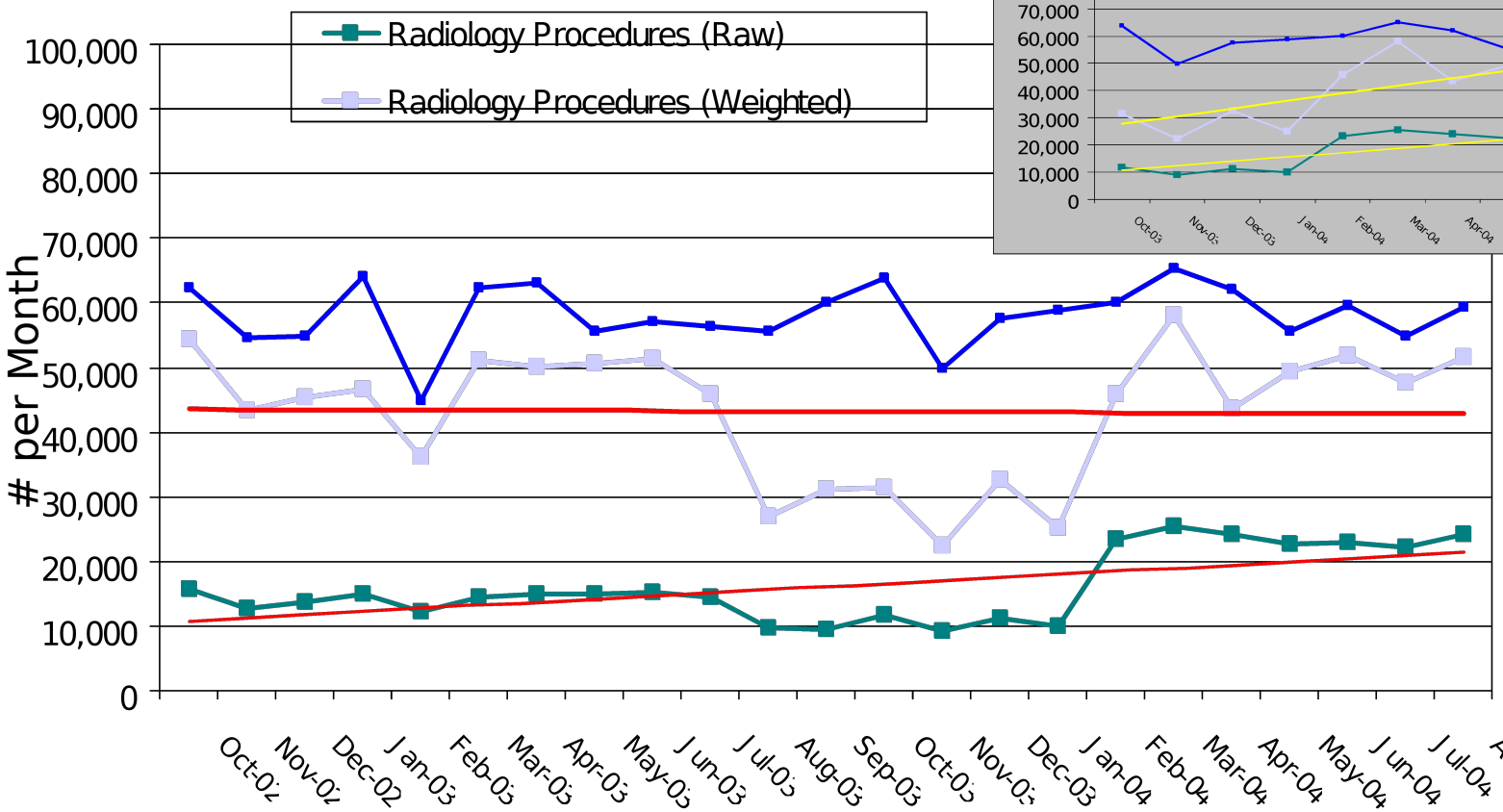
Dept Overview (cont)

- Solution: increased manning and improved efficiency of techs/radiologists

- Bottom Line: 4 techs deployed – 10 techs cut – civilian tech vacancies cover overhires' pay – contract techs being scrutinized

Diagnostic Imaging
Procedures vs. Outpatient Visits FY03-04



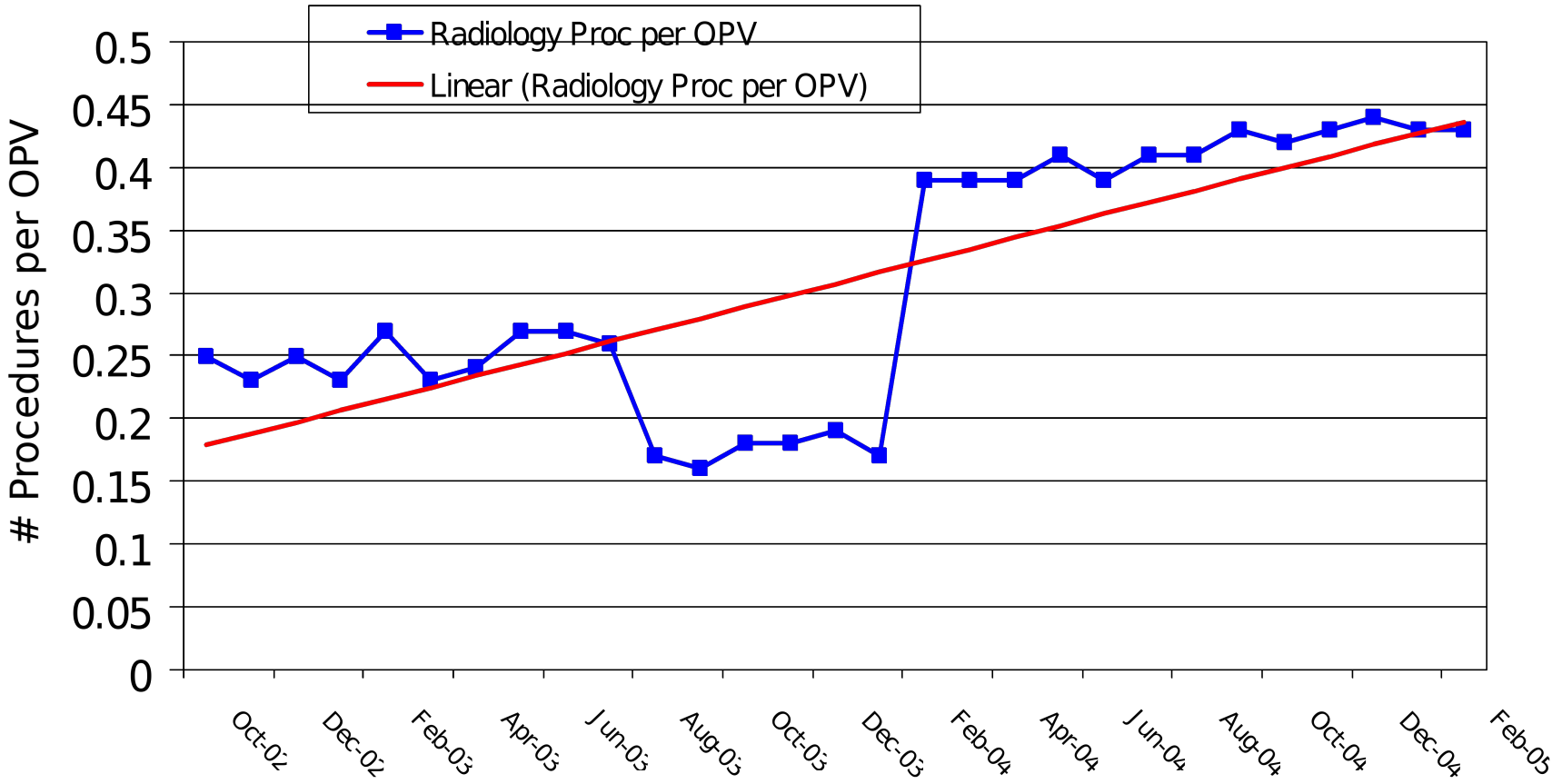


FY04 only

- FY03 vs. FY04: Raw procedures up 42%
- Weighted down 4% while OP visits up 1%
- Both Weighted & Raw increasing in FY04 (*inset*)

Source: Worldwide Workload
WHMC Intranet/E.I.C.

Radiology
Total Procedures per OP Visit FY03-05



- Overall: up 34% in FY05

Source: Worldwide Workload
WHMC Intranet/E.I.C.

Challenges and Opportunities Systems

- Integration of PACS, CHCS and Speech Recognition (SR)
  - Cost: $270K initial with approx $15K maintenance
  - Savings $500-800K/yr
  - Currently only unidirectional interface between PACS and CHCS
  - Improve report turnaround time
    - Days to minutes--currently no complaints concerning turnaround time.
  - Decrease troublesome 1% of studies where PACS and CHCS info do not correlate; improve staff efficiency

Challenges and Opportunities Systems (cont)

- CHCS limited for radiology
  - No bidirectional interface: requires technologist duplicate data entry/update
  - Additional 2-3 minutes/study is compounded by increased utilization rate
  - Resulting technologist inefficiency
    - Conservative estimate: 360,000 minutes/yr; 6000 hrs/yr; 750 man days/yr

2+ tech FTE's/yr ($75,000+)

Challenges and Opportunities Systems (cont)

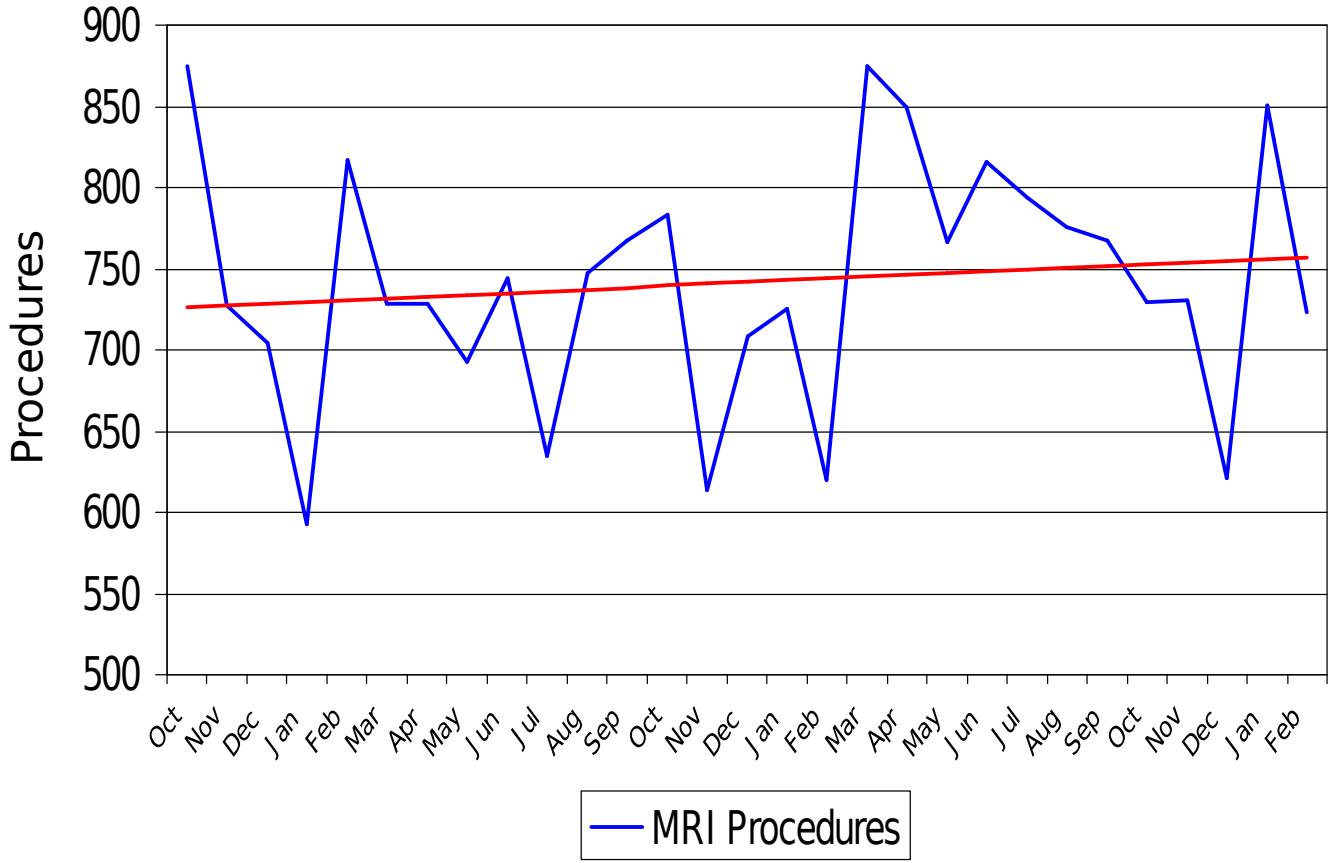
Solution

- Create a bidirectional interface – allowing the system to do the work rather than techs bridging the gap
- Solution is expensive and extends beyond WHMC

Challenges and Opportunities
High Cost Areas-MR

- MR throughput is dynamic based on staff technologist limitations
- Wait time historically fluctuates around 30 days; backlog occurs for staffing and seasonal reasons
- Mix of civilian (1) / military (10) techs hurts access
  - Military frequently in training status
  - MAPPG06: loss of 2 mil techs
  - Long training time for military techs--vulnerable for deployment, NCOA, PCS, etc.
- Unfunded requirement submitted for FY05

MRI
Direct Workload FY03 – FY05



	MR		
	FY03	FY04	FY05
October	875	719	729
November	727	477	731
December	595	735	628
January	704	598	851
February	593	620	723
March	817	875	
April	748	850	
May	728	763	
June	693	816	
July	744	795	
August	635	776	
September	747	767	
Total	8605	8789	3662
Average	717	732	732
% Change			2%

Source: CHCS

- Overall: up 2% since FY03

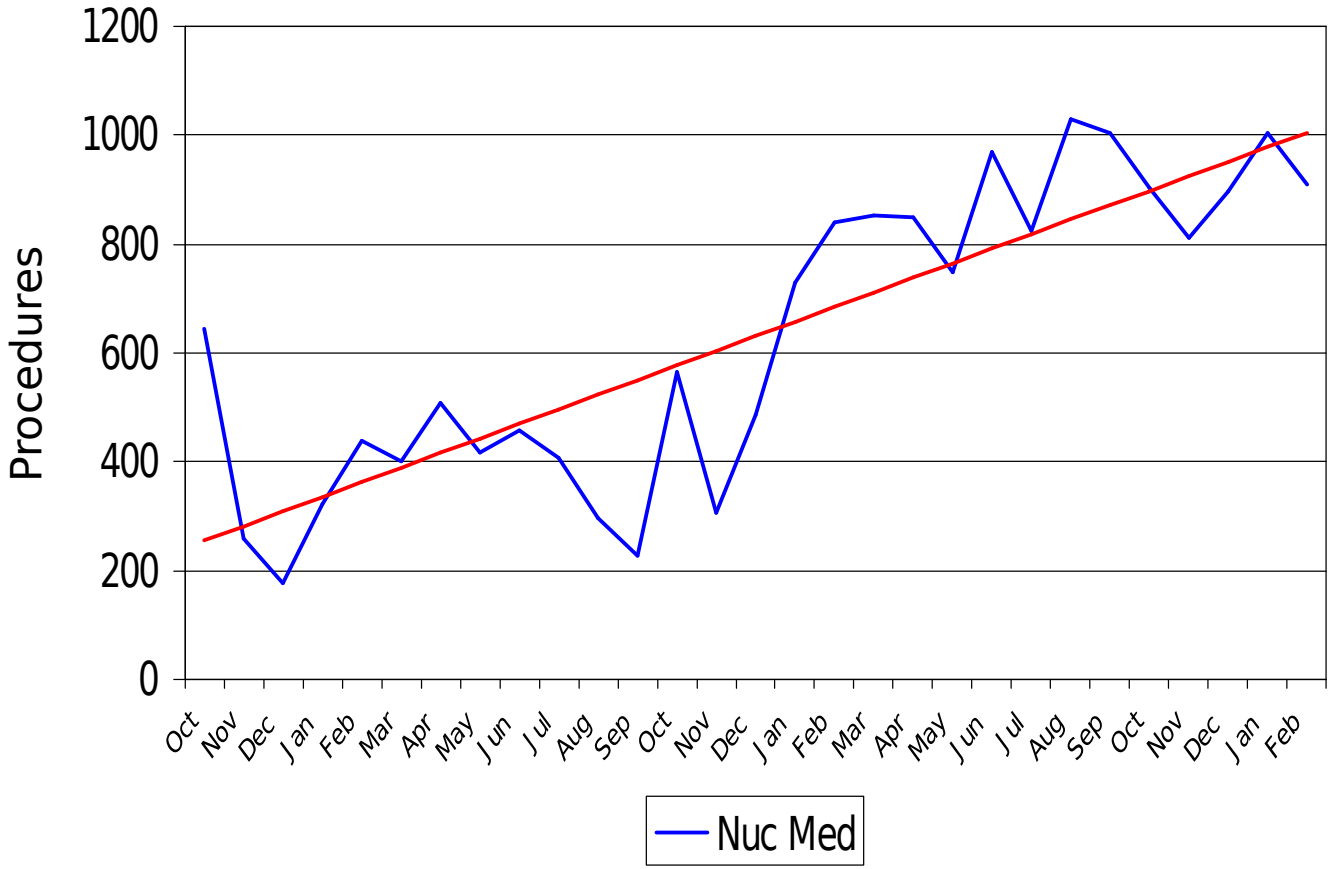
Challenges and Opportunities
High Cost Areas-MR

- MR Solution #1: "EXCITE" package approval —15-20% increased efficiency
- MR Solution #2: Improve mil/civ mix
  - In process of converting 1-2 GS positions to MR techs
- MR Solution #3: BPA for tech assistance on as needed basis
- MR Solution #4: Focus on meeting minimum access standards for prime enrollees – improve access to WHMC--optimal 14 days

Challenges and Opportunities
High Cost Areas-Nucs

- Nuclear Medicine increasing workload (38% over 2+yrs)
  - PET/CT scanner: increase PET throughput 100%
  - Limited workspace will need to expand in adjacent portion of radiology—will compound limited space problem currently encountered
  - Need to expand (reclaim) into PA and MM staff areas

Nuclear Medicine Workload FY03 – FY05



	Nuclear		
	FY03	FY04	FY05
October	518	565	902
November	420	307	811
December	498	487	896
January	699	730	1005
February	754	841	909
March	711.5	853	
April	670	849	
May	620.5	749	
June	498	968	
July	531.5	825	
August	354.5	1031	
September	441	1004	
Total	6716	9209	4523
Average	560	767	905
% Change			38%

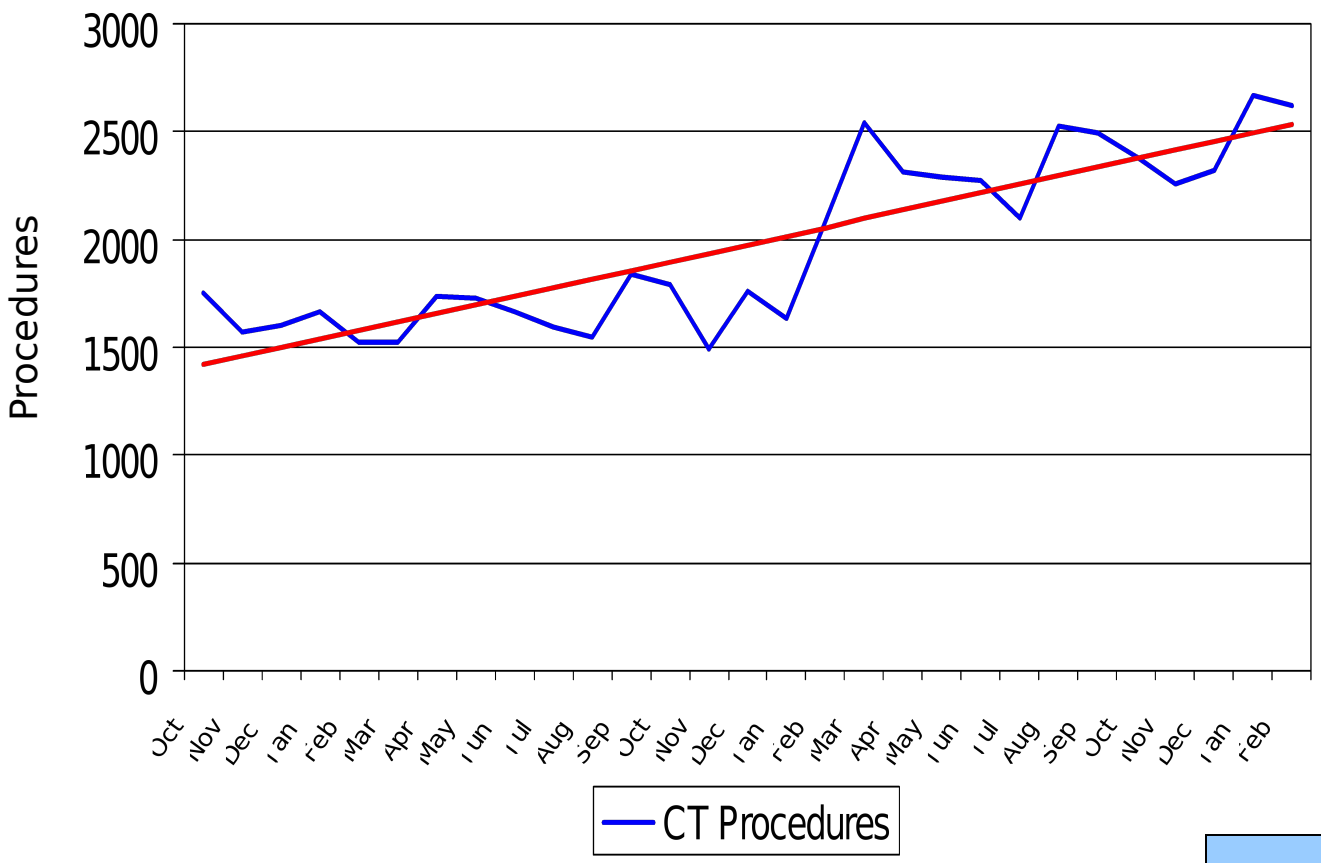
- Overa

Source: Worldwide Workload
WHMC Intranet/E.I.C.

Challenges and Opportunities
High Cost Areas-CT

- Workload increase 48% in 2 yrs
  - 50% workload is same day “add-ons”
- Expanded outpt appointments
  - Full schedule for both CTs for 2 shifts
  - 8 outpt appts daily on weekends
- Limited Preventive Maintenance
  - Highly utilized CT scanners go down more frequently

Computed Tomography (CT) Workload
FY03 – FY05



	CT		
	FY03	FY04	FY05
October	1756	1796	2384
November	1572	1491	2256
December	1602	1758	2325
January	1664	1638	2672
February	1520	2087	2623
March	1521	2546	
April	1920	2313	
May	1733	2288	
June	1668	2270	
July	1591	2103	
August	1545	2527	
September	1843	2498	
Total	19933	25313	12260
Average	1661	2109	2452
% Change			48%

- Overall: up 48% since FY03

Source: CHCS

Challenges and Opportunities
High Cost Areas

- CT Solution #1: Additional CT scanner in ED; will need 3 more techs and 604$ to cover new shifts to accommodate increasing utilization
- CT Solution #2: PET/CT scanner will give marginal increased capacity; need 604$ - TBD
- CT Solution #3: refer non-prime beneficiaries to the network, maintaining waiting times for facility
- CT Solution #4: More aggressive PM maintenance to reduce unscheduled work stoppage
- CT Solution #5: Reduce utilization through Clinical Pathway Guidance. Difficult and unpopular.

Summary of Needs

- Mechanism or procedure to bill professional portion of diagnostic imaging exams
- Dedicated coder for Radiology or local interface with coder
- Provide 604 funds to support Interventional Radiology
- Fund “Powerscribe” Speech Recognition Solution
- Bidirectional interface for CHCS
- Fund requirement for civilian MR technologists
- Wing endorsement of expanding CT capacity
- More aggressive CT PM contract
- Allow expansion of Nuclear Medicine and reclaim former radiology rooms

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